STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004444	A. BUILDING _____ B. WING _____	R-C 12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER HOUSE	2216 N RILEY HWY SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit to the Investigation of Complaint IN00096402 completed on 09-20-11. Complaint IN00096402 - corrected Survey date: December 1, 2011 Facility number: 004444 Provider number: 004444 AIM number: NA Survey Team: Mary Jane G. Fischer RN Census Bed Type: Residential: 15 Total: 15 Census Payor Type: Other: 15 Total: 15 Sample: 3 Walker House was found to be in compliance with 410 IAC 16.2 in regard to the Post Survey Revisit to the Investigation of Complaint IN00096402. Quality review 12/04/11 by Suzanne Williams, RN	{R 000}		